Consent to Treatment / Financial Responsibility / Authorization to Release Medical Information / Assignment of Benefits

I, _____ , consent to treatment to be rendered to (Patient or Responsible Party- please print)

me, my dependent, or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees**. Such fees or supplemental charges, may include, but are not limited to patient copays & deductibles In the event that my insurance coverage cannot be verified prior to service delivery, I agree that I will be responsible for payment in full. I further agree that I am responsible, as a supplemental charge, for payment of the full billed amount of charges not paid by my insurance company or its agent within 45 days from the date of their receipt of a claim. A fee of $50.00 is charged for missed appointments, unless canceled 24 hours in advance. The office does not file out of network claims but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service.**

I authorize Healthy Mind Behavioral Health Clinic., or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or to obtain payments. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent Healthy Mind Behavioral Health Clinic and its employees that I have in force, and am entitled to, the benefits of any applicable health plan which I have presented. I understand I have the right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in performance or healthcare operations of Healthy Mind Behavioral Health Clinic.

I assign any insurance benefits to Healthy Mind Behavioral Health Clinic

_____
Patient (Recipient of Care) (Please Print) Date

_____ Signature

_____
Responsible Party (if other than patient) (Please Print) Date

Signature of Responsible Party_____

We require a credit or debit card for services not covered by insurance:
Unpaid balances for services rendered **including those listed above**, may be charged to the following Credit or Debit Card [ ]MC [ ]VISA [ ]AMEX [ ]DISC

Card No. _____Exp. Date _____

Cardholder Name_____ (Please Print)

Cardholder Signature_____

Healthy Minds Behavioral Health

_____SIGNATURE OF PATIENT

_____Date